United States General Accounting Office

GAO

Briefing Report to Congressional Requesters

January 1990

MEDICARE

Increased Denials of Home Health Claims During 1986 and 1987

GAO/HRD-90-14BR

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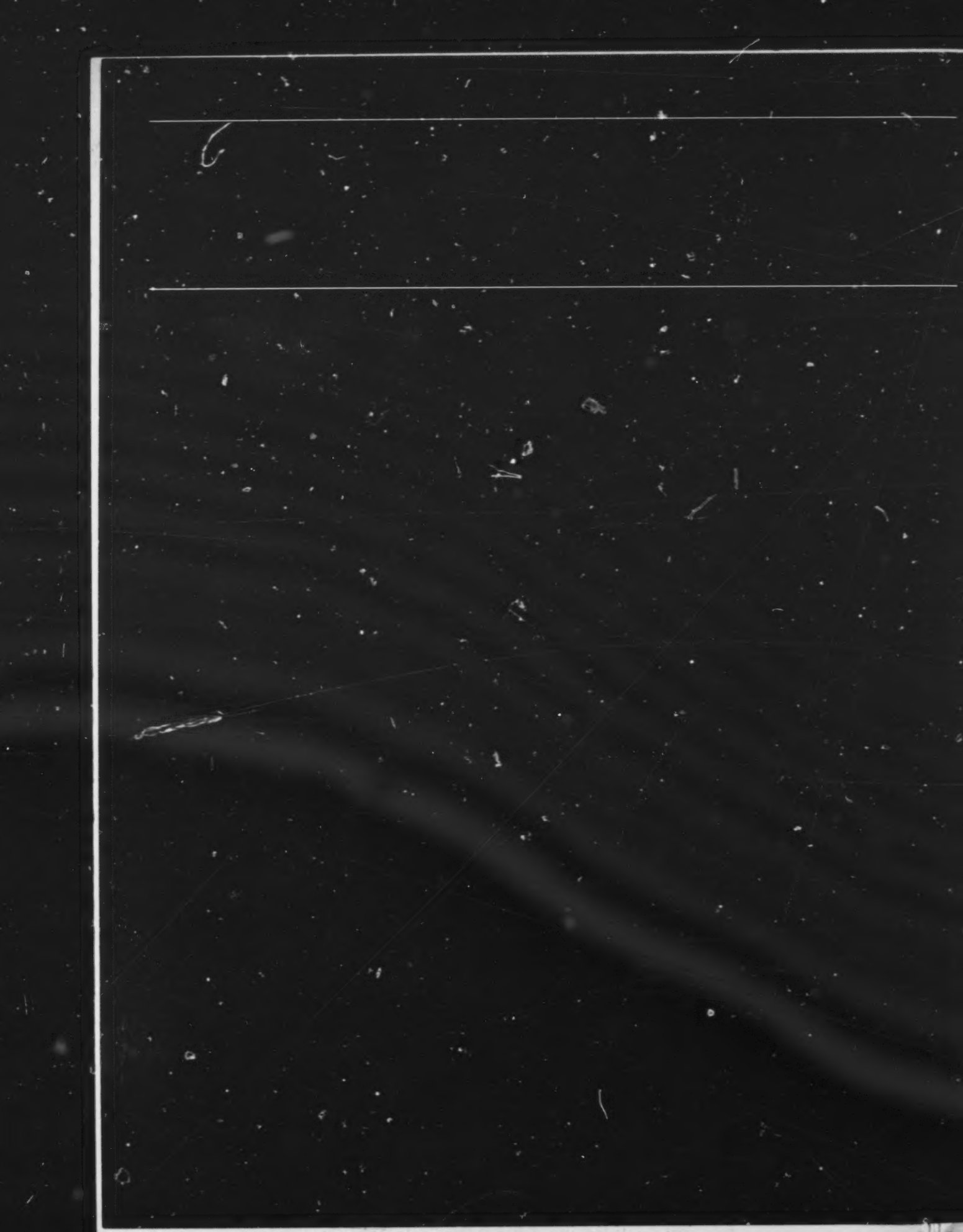

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-225004

January 24, 1990

The Honorable Olympia J. Snowe
House of Representatives

Dear Ms. Snowe:

In November 1987, you and a number of your colleagues (see app. I) expressed concern over the increased denials of Medicare home health care claims during 1986 and 1987. You asked us to analyze a number of issues related to these denials, including

- the reasons for the increased denials,
- the extent and causes of variation in denial rates among regions of the country,
- the number of home health agencies that lost their waiver of liability during this period, and
- the effects of the increased denials on the appeals process.

In addition, we determined the administrative and legislative changes that have decreased denials since 1987.

We reported our preliminary results in briefings with you on September 14, 1988, and the other requesters and their staffs on October 5, 1988. Also, at your request, we presented our preliminary results in an October 13, 1988, briefing before the Advisory Committee on Medicare Home Health Claims, established by the Medicare Catastrophic Coverage Act of 1988. This report elaborates on that information and presents the results of additional work performed since then.

Background

Medicare, administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services, is a health insurance program that covers almost all Americans age 65 and over and certain individuals under 65 who are disabled or have chronic kidney disease. Authorized under title XVIII of the Social Security Act, Medicare provides a home health care benefit for beneficiaries who are confined to their home (homebound), under a physician's care, and in need of part-time or intermittent skilled nursing care or physical or speech therapy.

By law, the home health benefit covers skilled nursing care services provided by Medicare-certified home health agencies or by others under contract to such an agency. Services provided by home health aides,

such as helping patients bathe, groom, and get into and out of bed, are not covered by the benefit unless the beneficiary requires skilled nursing care or physical or speech therapy.

HCFA contracts with insurance companies, called intermediaries, to process home health benefit claims and generally administer the benefit.[1] When an intermediary denies all or part of a claim, the home health agency may still receive payment under certain conditions. For example, if it has a history of few denials, it may be granted a waiver of liability, which protects beneficiaries and providers from being liable for noncovered services when they did not know and had no reason to know that the services were

- not medically reasonable and necessary or
- based on the need for custodial rather than skilled nursing care.

Denied claims for which an agency does not receive payment may be appealed.

In previous reviews, GAO and HCFA's Bureau of Quality Control concluded that HCFA was paying for noncovered services because of material weaknesses in internal controls over payment for home health services. In 1986, GAO reported that uncertainty over the meaning of such terms as homebound and intermittent care may result in inconsistent coverage determinations by the intermediaries.[2] In response to these studies and to certain legislative changes, HCFA initiated a number of actions between 1985 and 1987 intended to minimize Medicare payments for noncovered home health services and provide for more consistent administration of the home health benefit by its fiscal intermediaries.

Following these actions, home health bill denials increased from about 3.1 percent of bills processed in the first quarter of fiscal year 1985 to a peak of 9.0 percent for the first quarter of fiscal year 1987 (see pp. 15 to 16). The number of denied bills increased from about 186,000 in fiscal

[1]Home health agencies can be freestanding or provider based. Freestanding agencies are those that are not a subdivision of another Medicare provider, such as a hospital or skilled nursing facility. In fiscal year 1986 there were 47 intermediaries; during fiscal year 1987 the number of intermediaries processing claims for freestanding agencies was reduced to 10 as required by the Deficit Reduction Act of 1984. One of the 10 left the program in December 1988, leaving 9 intermediaries processing claims for freestanding agencies. During fiscal year 1989 all provider-based home health agencies were transferred to these nine intermediaries.

[2]Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986).

year 1985 to about 408,000 in fiscal year 1987. Since 1987, the denial rate has steadily declined to about 4.3 percent.

Reasons for Increased Denials

During congressional hearings held throughout the country in 1986 and 1987, industry officials, providers, and beneficiaries raised a number of concerns about HCFA actions they viewed as causing denials and eroding the home health benefit. Legislation has been enacted to address many of these concerns (see app. II).

Although many factors contributed to the increased denials of home health claims in 1986 and 1987, we believe the increases can be attributed primarily to certain administrative changes:

- The number of claims subjected to detailed review increased from about 25 to over 60 percent. Since most denials result from detailed review, this could be expected to more than double the number of denied claims.
- Standardized medical information forms requiring more detailed information on which to make claims decisions were instituted; denials increased because intermediaries had more information on which to make decisions and also because they denied claims where forms were not filled out completely.
- Claims payment activities for freestanding home health agencies were consolidated under 10 regional fiscal intermediaries during fiscal year 1987. Because of the variation in intermediaries' medical review performance and interpretation of coverage criteria, the change in intermediaries may have resulted in increased denials until the home health agencies adjusted to the review practices of their new intermediaries.
- Prior to the consolidation, HCFA evaluated the effectiveness of the review procedures of these 10 intermediaries; this evaluation resulted in increased denials as the intermediaries changed their review procedures in response to HCFA's findings. Immediately following the HCFA evaluation, the home health claim denials were the highest ever. (See pp. 18 to 21.)

Regional Variation in Denial Rates

HCFA's quarterly data on denials of home health agency bills show significant variation of denial rates among HCFA regions, particularly during fiscal years 1986 and 1987, when denials were increasing. The variation resulted in part from differences in review practices among the regional fiscal intermediaries. For example, the volume of claims medically

reviewed by intermediaries varied, half of the intermediaries were denying claims in 1986 when information was missing from the claim forms while others were not, and there were inconsistent interpretations of certain coverage criteria. Inconsistencies among intermediaries in reporting denials to HCFA also led to variation in denial rates. Half of the intermediaries reported only denials that resulted from their detailed review process; they tended to have lower denial rates than the other half, which reported denials from detailed review and other sources, such as the initial review of claims for eligibility. (See pp. 22 to 24.)

More Agencies Lost Their Waiver of Liability

Precise data on the number of home health agencies that lost their waiver of liability during this period and the effects of loss of waiver on beneficiaries were not available. Data provided to GAO by 8 of the 10 regional intermediaries, however, shows that the percentage of agencies that lost their waiver of liability increased from about 16 percent for the quarter beginning February 1, 1986, to about 32 percent for the quarter beginning November 1, 1986. Also, regional intermediaries did not use consistent methods to determine agencies' eligibility for the waiver, creating potential inequities in the granting of waivers.

Home health industry officials say that the loss of waiver adversely affects beneficiaries because providers without waivers may be reluctant to provide certain services to beneficiaries when they have any doubts about whether the service is covered. Also, providers may refuse to accept new patients when they are not sure the patient will qualify for home health benefits. (See pp. 25 to 27.)

Agencies Appealed More Denied Claims

The number of denied claims appealed to intermediaries and administrative law judges increased substantially from about 10,000 in fiscal year 1986 to about 64,000 in fiscal year 1988. The percentage of denied claims reversed at these levels also increased. However, the increase in reversals does not necessarily mean that the claim should have been paid when first submitted; many reversals occurred because agencies submitted the additional information to the intermediary needed to approve the claim. (See pp. 28 to 33.)

Recent Changes Have Addressed the Denial Issue

Since 1987, the number of denials has decreased substantially to about the 1985 level even though the number of claims being subjected to detailed review has continued at over 60 percent of claims processed. HCFA has instituted specific administrative actions that have decreased denials and also resulted in a narrowing of the variation in regional denial rates. As denials have declined, so have the number of home health agencies that have lost their waiver of liability. (See pp. 33 to 34.)

The Congress has also passed legislation clarifying some of the home health benefit provisions, giving HCFA specific requirements for administering the benefit, and increasing the home health services available under Medicare and other programs. However, some of these provisions were repealed by the Medicare Catastrophic Coverage Repeal Act of 1989. (See app. II.)

Scope and Methodology

We did our work at HCFA's headquarters in Baltimore and its Boston regional office. We analyzed readily available statistics on home health claims, denials, appeals of denials, and numbers of providers who had lost their waiver of liability. We did not verify the accuracy of the data intermediaries were reporting to HCFA but did identify inconsistencies in how certain data were reported.

We visited one regional fiscal intermediary and surveyed all 10 regional intermediaries through a mail questionnaire. We also visited two home health agencies in Vermont and two in Maine as well as an association that has been representing the interests of more than 5,000 home health providers. We also reviewed recent legislation, a court decision, and several congressional hearings pertaining to home health issues.

We did not obtain formal written agency comments on this report; however, we discussed its contents with HCFA officials and incorporated their comments where appropriate. Copies of this report are being sent to the other requesters, the congressional committees having jurisdiction over matters discussed in the report, the Secretary of Health and Human Services, and other interested parties. If you have any questions regarding

this report, please call me at (202) 275-5451. Other major contributors to this report are listed in appendix IV.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

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Abbreviations

ALJ	administrative law judge
GAO	General Accounting Office
HCFA	Health Care Financing Administration

Background

Medicare, administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services, is a health insurance program that covers almost all Americans age 65 and over and certain individuals under 65 who are disabled or have chronic kidney disease. The program, authorized under title XVIII of the Social Security Act, provides protection under two parts. Part A, the hospital insurance program, covers inpatient hospital services and certain post-hospital care in skilled nursing homes and patients' homes. Part B, the supplementary medical insurance program, covers primarily physician services. Although home health care is financed under both parts, about 98 percent of home health is paid under part A.

Home health care generally is defined as health care prescribed by a physician and provided to a person in his or her own home. Home health benefits covered by Medicare are, by law, oriented toward skilled nursing care and include

- part-time or intermittent nursing care provided by or under the supervision of a registered nurse;
- physical, occupational, or speech therapy;
- medical social services to help patients and their families adjust to social and emotional conditions related to the patients' health problems;
- part-time or intermittent home health aide services;[1] and
- certain medical supplies and equipment.

In fiscal year 1987, home health agencies made about 36.1 million visits to 1.37 million Medicare beneficiaries at an estimated cost of $2.3 billion.

To qualify for Medicare home health care, a person must be confined to his or her residence (homebound), be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical or speech therapy. The services must be furnished under a plan of care prescribed and periodically reviewed by a physician. Individuals who need help with activities of daily living, such as eating or using the toilet, but who do not need skilled nursing care or physical or speech therapy, do not qualify for Medicare home health benefits. In addition, Medicare beneficiaries who are not homebound but need part-time or intermittent skilled nursing care are ineligible for these benefits.

[1]Home health aides, among other things, help patients bathe, groom, get into and out of bed, use the toilet, take self-administered medicines, and exercise.

Home Health Agencies

Medicare home health services must be furnished by Medicare-certified home health agencies or by others under contract to such an agency. Agencies participating in the program must meet specific requirements of the Social Security Act. The number of Medicare-certified home health agencies increased from 2,212 in 1972 to about 5,661 in 1988. This growth has primarily taken place in facility-based and for-profit home health agencies, while the number of more traditional nonprofit home health providers—visiting nurse associations and government agencies—has declined slightly.[2]

Program Administration

HCFA administers the home health care program through nine regional fiscal intermediaries—eight Blue Cross plans and Aetna Life and Casualty (Florida Aetna).[3] These intermediaries

- serve as a communication channel between home health agencies and HCFA,
- make payments to home health agencies for covered services provided to Medicare beneficiaries, and
- establish and apply payment safeguards to prevent program abuse.

Providers submit their claims for home health visits and other items to the intermediaries. To identify noncovered services, intermediaries evaluate the claims through a utilization review process.[4] This process includes a medical review program whereby specified claims are reviewed to determine if the services billed were medically necessary and appropriate and covered by the home health benefit. Through this process, intermediaries decide to either pay the claim in full or deny all or part of it. Under certain conditions, providers may still receive payment for denied visits under the waiver of liability or through the appeals process described below.

[2]Facility-based agencies include hospitals, skilled nursing facilities, and rehabilitation-based agencies. Visiting nurse associations are generally community-based agencies supported by contributions and patient fees. Government agencies consist mostly of county or local public health departments.

[3]There were originally 10 regional fiscal intermediaries; however, Prudential Insurance Company (New Jersey Prudential) withdrew from the program as of December 31, 1988.

[4]Noncovered services include those that are (1) not reasonable or medically necessary, (2) provided to beneficiaries who are not homebound, and (3) in excess of the services called for by approved plans of treatment.

Waiver of Liability

The waiver of liability provision of the Social Security Act protects beneficiaries and providers from being liable for noncovered services when they did not know and had no reason to know that the services were

- not medically reasonable and necessary or
- based on the need for custodial rather than skilled nursing care.

When these situations occur HCFA will pay providers for the cost of the services as long as the number of denials does not exceed 2.5 percent of total visits billed. When a provider exceeds the 2.5-percent rate in a calendar quarter, Medicare will not reimburse the provider for such services, usually for the next 3-month period.

The Omnibus Budget Reconciliation Act of 1986 created a second waiver of liability category under which the beneficiary is not liable when services are denied for "technical" reasons (i.e., because the beneficiary was not "homebound" or did not require "intermittent" skilled nursing care).[5] HCFA pays providers for services denied for technical reasons using the same 2.5-percent criterion that applies to "medical necessity" denials.

Appeals Process

Under an appeals process created by the Social Security Act, a decision to deny payment for services may be appealed to the intermediary for reconsideration regardless of the amount involved. The intermediary's reconsideration decision may be appealed to a Social Security Administration administrative law judge (ALJ) if the amount in controversy is $100 or more. Where the amount is $1,000 or more, denials upheld by the ALJ may be appealed to federal courts. Appeals must be filed within 60 days from the date of the decision at each level of the process.

Beneficiaries may appeal any denials and may appoint a qualified individual (including a provider) to represent them in the appeals process. If the beneficiary appeals, the provider is made party to the proceedings.

A provider may initiate an appeal if the ultimate liability rests with (1) the provider or (2) the beneficiary and the beneficiary will not exercise his or her appeal rights. A provider cannot appeal claims paid under the waiver of liability provision.

[5]The Medicare Catastrophic Coverage Act of 1988 extended the waiver, which became effective July 1, 1987, to November 1, 1990. This provision was not repealed by the Medicare Catastrophic Coverage Repeal Act of 1989.

Prior Concerns Raised Over Administration of the Program

Through reports issued in 1981 and 1986, we criticized HCFA's administration of the Medicare home health benefit.[6] We reported that about 27 percent of the visits reviewed at 37 agencies and paid under the benefit were questionable or improper. We attributed those problems to the vagueness of the coverage criteria (particularly uncertainty over the exact meaning of terms such as "homebound" and "intermittent care"), insufficient information being submitted with the claims upon which to base a coverage decision, and poor performance of the intermediaries in reviewing claims.

HCFA's 1984 evaluation of the home health program also questioned administration of the benefit by the fiscal intermediaries.[7] HCFA nurses reviewed a sample of beneficiaries' records previously reviewed by seven fiscal intermediaries under the utilization review program. The intermediaries had denied 8 percent of the claims reviewed; the HCFA nurses said they should have denied 45 percent.

Concerned about the consistency with which intermediaries interpreted such terms as "intermittent care," the Congress, through language in the Deficit Reduction Act of 1984, directed the Secretary of Health and Human Services to reduce the number of intermediaries administering the home health program to 10 or fewer by July 1, 1987. The reduction was intended to improve program management and promote consistency in program administration.

In response to the above concerns HCFA began instituting a number of administrative changes in 1985 to reduce payments for noncovered services, improve program management, and ensure more consistent claims determinations by intermediaries.

Home Health Denials Increased in Fiscal Years 1986-87

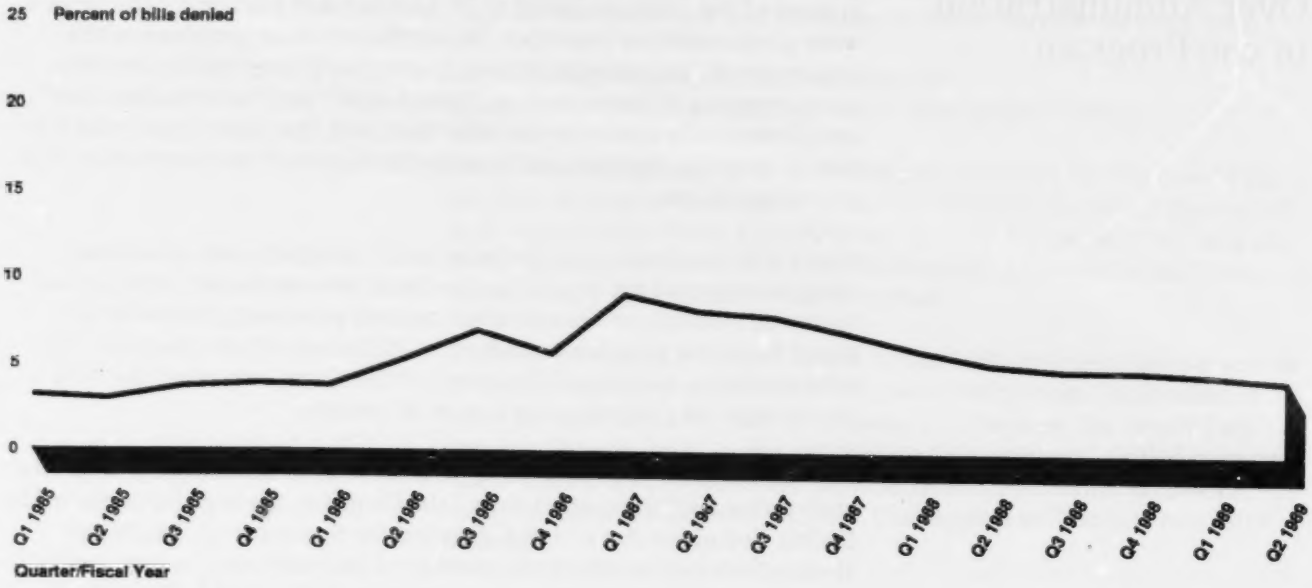
Home health bill denials increased from 3.1 percent of total bills processed in the first quarter of fiscal year 1985 to a high of 9 percent in the first quarter of fiscal year 1987. Since then, they have gradually declined. (See fig. 1.1.)

[6]Medicare Home Health Services: A Difficult Program to Control (HRD-81-155, Sept. 26, 1981).

Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986).

[7]1984 National Home Health Study. An unpublished study by HCFA's Bureau of Quality Control.

Figure 1.1: Increase in Home Health Denials—National Totals



Source: HCFA.

As a result of the increased denials, more denied claims were appealed and the number of home health agencies that lost their waiver of liability also increased.[8] Because of the increased denials, some industry representatives charged that HCFA was attempting to dismantle Medicare's home health benefit and filed lawsuits contending that HCFA violated the requirements of the Administrative Procedure Act in implementing certain changes to the home health program.[9] During congressional hearings held throughout the country in 1986 and 1987, industry officials, providers, and beneficiaries raised concerns about HCFA actions they viewed as causing denials and eroding the home health benefit. Legislation has been enacted to address many of these concerns (see app. II).

[8]This means that they did not get paid for their denied claims until they regained their waiver.

[9]The act requires agencies to notify the public through the Federal Register to allow for comment on proposed regulations before they are promulgated.

Objectives, Scope, and Methodology

Because of the controversy surrounding the administration of the home health benefit, Representative Olympia J. Snowe and 66 other Members of Congress requested that we determine (1) the reasons for the increased denials, (2) the extent and causes of variation in denial rates among regions of the country, (3) the number of home health agencies that lost their waiver of liability during the period of increased denials, and (4) the effects of the increased denials on the appeals process. We also identified actions taken by HCFA and the Congress since the period of increased denials.

We did our work at HCFA's headquarters in Baltimore and its regional office in Boston; we visited one regional fiscal intermediary—Blue Cross and Blue Shield of Maine (Maine Blue Cross) and surveyed the 10 regional fiscal intermediaries that service freestanding home health agencies by use of a mail questionnaire. We visited two home health agencies in Vermont and two in Maine that congressional staff from those states identified as having specific concerns about the administration of the home health benefit. We also visited the National Association for Home Care, an industry association representing the interests of more than 5,000 home health providers.

We (1) reviewed prior GAO and HCFA reports, recent legislation, congressional hearings, and an August 1988 court decision (Duggan v. Bowen) affecting the home health benefit; (2) gathered and analyzed statistics from HCFA and other sources on home health claims, denials, appeals of denials, and numbers of providers who had lost waivers of liability; and (3) interviewed HCFA, home health industry, and intermediary officials.

We did our work from January 1988 to January 1989 in accordance with generally accepted government auditing standards, with the exception that we did not verify the accuracy of the data intermediaries were reporting to HCFA. However, through our questionnaire we identified inconsistencies in how certain data are reported to HCFA; these inconsistencies are discussed later in the report.

Reasons for Increased Denials

In response to the concerns raised by GAO and the Health Care Financing Administration's Bureau of Quality Control between 1981 and 1986, HCFA implemented a number of changes to improve the administrative control over the home health program. These changes included

- implementing standardized medical information forms to provide better information on which to make payment decisions,
- increasing the number of claims medically reviewed before payment,
- consolidating medical review for freestanding home health agencies under 10 regional intermediaries, and
- evaluating the regional intermediaries' medical review practices just before consolidation.

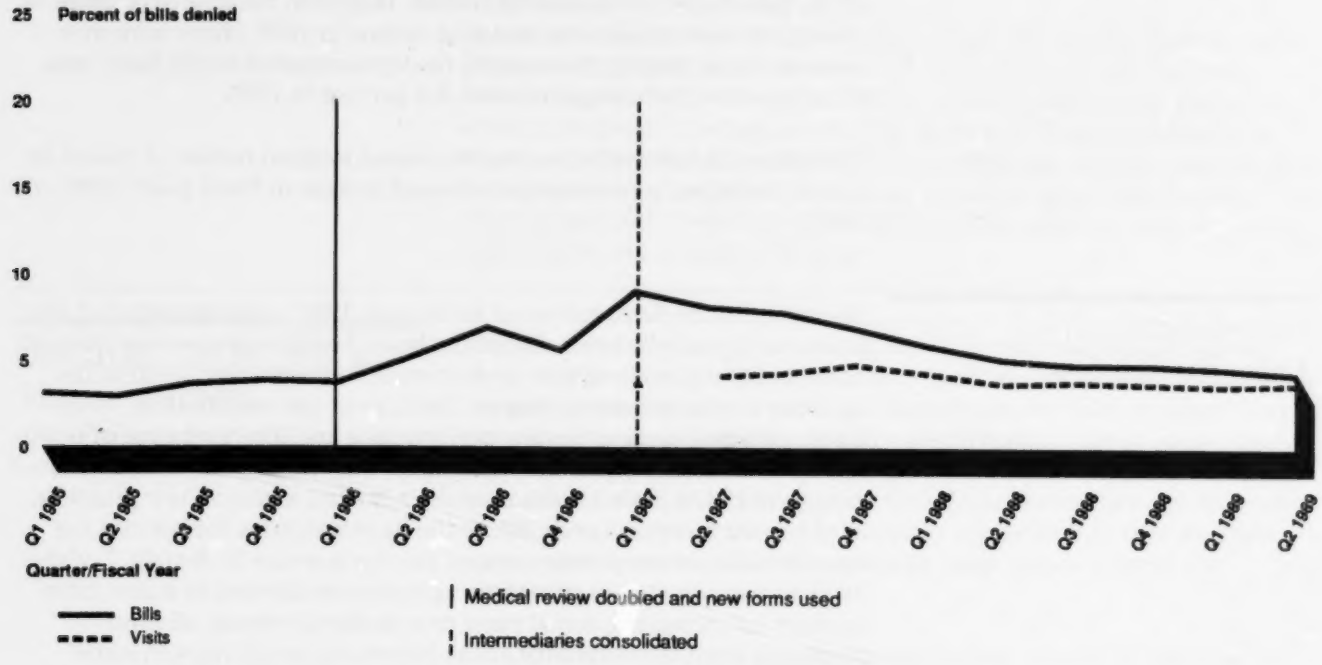
We believe many of the denials of home health claims in 1986 and 1987 can be attributed to HCFA's implementation of these changes; the 10 regional intermediaries generally agree. As shown in figure 2.1 the increases in denial rates in fiscal years 1986 and 1987 roughly correspond to the period of implementation of these changes.

Standardized Medical Information Forms

In August 1985, HCFA implemented standardized medical information forms for home health agencies to use in requesting payment from intermediaries. The forms (HCFA forms 485 and 486) gave medical reviewers more detailed information on each beneficiary's general physical condition, "homebound" status, functional limitations, nutritional requirements, services prescribed, and services received. The additional information was intended to increase the accuracy and consistency of coverage decisions. HCFA requires home health agencies to submit the forms 485 and 486 with the initial claim and the claim closest to the recertification date 60 days later. Interim bills submitted before recertification need not be accompanied by these forms.

This initiative led to more claims denials because (1) medical reviewers had more information on which to make coverage decisions, and (2) some intermediaries denied claims because certain information was missing, instead of requesting the required data. The regional intermediaries cited denials associated with the implementation of the new forms as a primary reason for increases in fiscal year 1986.

Figure 2.1: Relationship Between Program Changes and Increased Denials



Source: HCFA.

Increased Medical Review

The Consolidated Omnibus Budget Reconciliation Act of 1985 more than doubled the funds available for medical review and audit of home health and other Medicare claims. During fiscal year 1986, HCFA implemented the changes that this increased funding allowed. Before fiscal year 1986, intermediaries performed medical reviews on about 25 percent of home health claims and, therefore, paid the other 75 percent without detailed reviews. HCFA instructed intermediaries to perform medical reviews on every home health claim with a HCFA form 485 and a 486 attached; interim bills did not generally receive such reviews. HCFA officials told us that this resulted in intermediaries performing medical reviews on about 62 percent of the home health claims processed in fiscal years 1986 and 1987 (more than double the percentage reviewed in fiscal year 1985).

The increased number of bills subjected to medical review resulted in more denials and higher denial rates even though the percentage of bills

being denied during medical review did not increase significantly. For example, in both 1985 and 1987, intermediaries denied about 10 percent of the bills subjected to medical review. However, because over twice as many bills were subjected to medical review in 1987, there were over twice as many denials. As a result, the HCFA-reported denial rate,[1] was 7.9 percent in 1987 compared with 3.4 percent in 1985.

The regional intermediaries cited increased medical review of claims as one of the primary reasons for increased denials in fiscal years 1986 and 1987.

Consolidation of Intermediaries

Beginning in the first quarter of fiscal year 1987, administration of the home health benefit for freestanding home health agencies was consolidated under 10 regional intermediaries; this caused over 3,000 of the agencies to change intermediaries. Because of the variation in intermediaries' medical review performance and interpretation of coverage criteria, the change in intermediaries may have resulted in increased denials until the home health agencies adjusted to the review practices of their new intermediaries. While the intermediaries did not cite the consolidation as the primary reason for the increase in denials, 7 of the 10 cited the adjustment period for agencies transferred to a new intermediary as increasing denial rates to a moderate extent; all intermediaries cited the consolidation as increasing denial rates to some extent.

Strengthening of Intermediary Performance

Just before the consolidation to 10 regional intermediaries, HCFA attempted to strengthen program controls and obtain more consistent decisions from the intermediaries by evaluating the appropriateness of their medical review decisions. This evaluation, conducted by HCFA's Health Standards and Quality Bureau, was intended to identify individual intermediary medical review training needs. Preliminary results of the evaluations were sent to the intermediaries and HCFA's regional offices in September 1986, but no final report was issued.

The Health Standards and Quality Bureau evaluation found about 28 percent of the visits reviewed should have been denied, but that intermediaries had denied only 2.7 percent. In the first quarter of fiscal year 1987, immediately following the bureau's evaluation, the home health claim denials were the highest ever. The intermediaries cited the

[1]Bills denied divided by bills processed.

bureau's review as the most significant reason for the increase in denials during fiscal year 1987.

In October 1986, before the Health Standards and Quality Bureau could implement training programs based on their evaluation, HCFA transferred responsibility for monitoring the quality of medical review decisions by regional intermediaries to its Bureau of Program Operations. Since assuming this responsibility, that bureau has tried to promote uniform and accurate application of medical review guidelines by conducting quarterly meetings with regional intermediaries and reviewing case studies of coverage decisions.

Savings Ratio Not a Major Factor

There have been other reasons suggested by the home health industry as having been responsible for the increased denials in 1986 and 1987. A frequently cited reason is the 5 to 1 savings-to-cost ratio standard that HCFA used in evaluating intermediary performance. One of many standards in HCFA's Contractor Performance Evaluation Program, this standard required that intermediaries recover $5 in benefit savings for every $1 spent on medical review. The industry contends that this standard encouraged intermediaries to arbitrarily deny claims to meet the standard.

HCFA officials contend that, since the savings-to-cost ratio was only one of many performance standards, an intermediary that arbitrarily denied claims to meet this standard would adversely affect its performance when measured against other standards (such as those relating to the accuracy of coverage decisions). In March 1987, HCFA reduced the standard to a 2 to 1 ratio but did not use the standard in the fiscal year 1987 evaluations of intermediary performance. HCFA eliminated the standard completely from the fiscal year 1988 contractor evaluations because of the controversy and uncertainty associated with its use.

In response to our questionnaire, 7 of the 10 regional intermediaries told us that the 5 to 1 ratio had little effect on increased denials in fiscal years 1986 or 1987. Overall, they felt that of all the reasons discussed in the questionnaire, this standard had the least effect on the increased denials.

Reasons for Varying Denial Rates Among HCFA Regions

The Health Care Financing Administration's quarterly data on denials of home health agency bills for fiscal years 1985 through 1988 show significant variation of denial rates among HCFA regions. The variation results in part from differences in medical review practices among the regional intermediaries and inconsistencies among intermediaries in reporting denials to HCFA.

Extent of Regional Variation

Two of the 10 regional intermediaries had relatively low denial rates throughout the 4-year period—Florida Aetna's highest rate was 5.6 percent in the first quarter of fiscal year 1987, and New Jersey Prudential peaked at 7.3 percent in the fourth quarter of fiscal year 1987. The other eight intermediaries experienced dramatic increases in denial rates in at least one quarter of fiscal year 1987, though rates for all decreased in fiscal year 1988. For example, the denial rates for Maine Blue Cross were consistently below 5 percent until the first quarter of 1987, when they increased to about 15 percent. (See fig. 3.1 for denial rates for selected intermediaries and app. III for denial rates for all regional intermediaries.)

Reasons for Regional Variation

Regional variation in denial rates results primarily from differences in intermediaries' medical review practices and methods for reporting denials to HCFA.

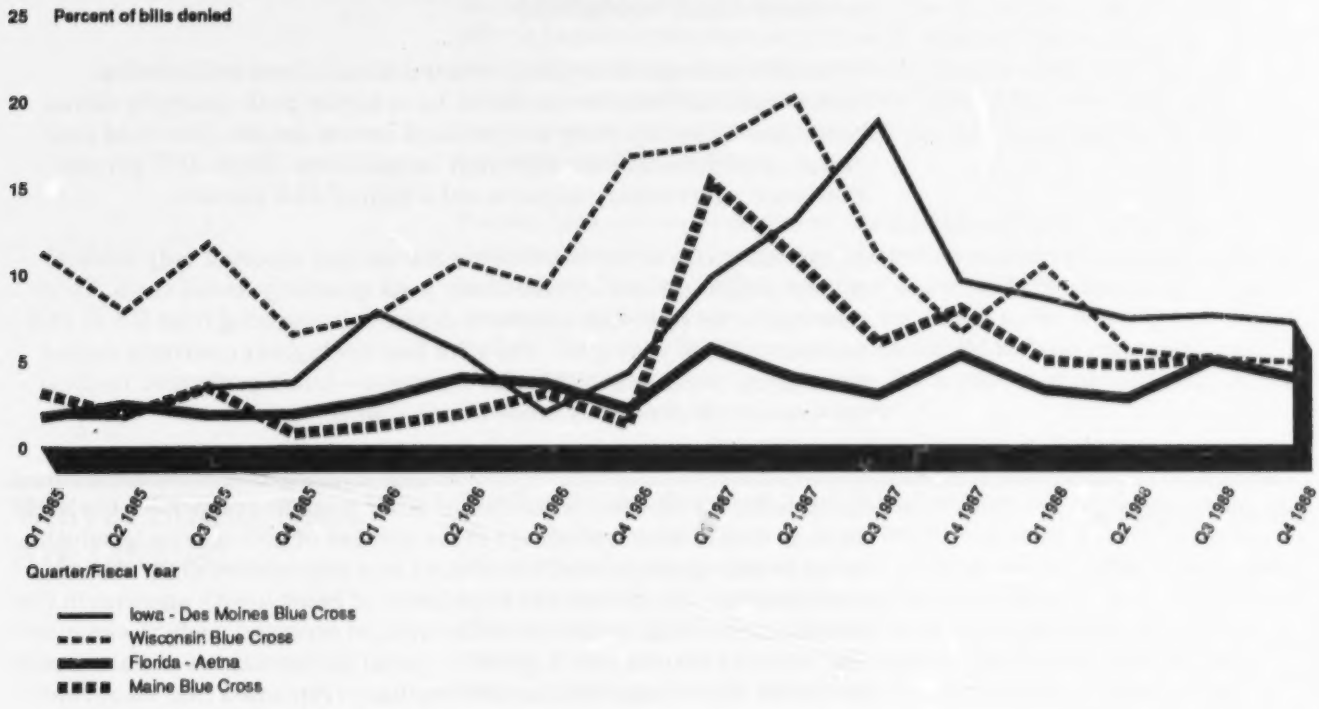
Differences in Medical Review Practices

The intermediaries' responses highlighted a variety of medical review practices and guideline interpretations. For example:

- The volume of claims medically reviewed by intermediaries varied. (The national average was 62 percent.) One intermediary, through the use of a utilization review screen, medically reviews 100 percent of its claims.[1] That intermediary had the highest quarterly peak denial rate of all the regional intermediaries—20.1 percent. Screens were used to a varying extent by four other intermediaries for all or part of 1987.
- Five of the intermediaries indicated that they were denying claims in fiscal year 1986 when information was missing on HCFA forms 485 or 486. In May 1987, HCFA instructed intermediaries to stop denying claims because of missing information and, instead, to request the necessary information.

[1]Screens are parameters used to identify claims that should be subjected to more detailed review.

Figure 3.1: Denials of Home Health Agency Bills for Selected Regional Intermediaries



Source: HCFA.

- Inconsistent interpretations of certain coverage definitions continued. For example, as a result of meetings among themselves, the intermediaries identified a number of areas of inconsistent interpretations and requested HCFA to clarify definitions of a number of terms, such as "daily care." HCFA responded to each request.

Inconsistent Reporting of Denials

The 10 regional intermediaries were not consistent in the way they reported denial statistics to HCFA at the time of our review. HCFA requires intermediaries to report denials as either (1) medical denials or (2) nonmedical denials. Nonmedical denials can result from both the initial clerical review of claims or from the medical review process.[2] Half reported

[2]Reasons for nonmedical denials occurring during medical review include duplicate services being rendered or noncovered supplies being provided.

only denials occurring as a result of medical review; the others reported denials from both medical review and other sources, like the initial review of claims for eligibility.

Thus, five intermediaries that reported denials from both medical review and other sources tended to have higher peak quarterly denial rates than those reporting only medical review denials. Four had peak denial rates in fiscal year 1987 that ranged from 18.6 to 19.7 percent. The other intermediary experienced a high of 13.6 percent.

In contrast, four of the five intermediaries that reported only medical review denials tended to have lower peak quarterly denial rates. These intermediaries had peak quarterly denial rates ranging from 5.6 to 15.2 percent in fiscal year 1987. The fifth had the highest quarterly denial rate during fiscal year 1987—20.1 percent—but it performed medical reviews of 100 percent of home health claims.

Other Reasons

Intermediaries reported a number of other possible reasons for the variation in denial rates, including (1) the number of and quarter in which home health agencies were transferred to a new intermediary during consolidation, (2) the size and experience of home health agencies in the intermediary's region, and (3) differences in accepted medical and nursing practices between the regions. Unusual circumstances can also result in variation. For example, one intermediary responded that inappropriate and even fraudulent billing practices at several of its large providers skewed its denial rates.

Effect of Increased Denials on Waiver of Liability Status

Loss of waiver of liability (see p. 14) adversely affects an agency because it is not paid for denied claims until it regains its waiver. Home health industry officials say that the loss of a waiver also adversely affects beneficiaries because providers without waivers may be reluctant to provide certain services to beneficiaries when they have any doubts about whether the service is covered. Also, providers may refuse to accept new patients when they are not sure the patient will qualify for home health benefits.

Precise data are not available on the number of home health agencies that lost their waiver because of the increased denials. Data provided to us by fiscal intermediaries, however, show that the percentage of agencies that lost their waiver generally increased when home health claims denials increased. Because intermediaries did not use consistent methods to determine agencies' eligibility for a waiver of liability, differences exist in the availability of the waiver.

Waiver Status Data Are Limited

The Health Care Financing Administration does not routinely collect statistics on the waiver status of home health agencies, but did collect such information for the period July 1987 through March 1988 in response to a requirement in the Omnibus Budget Reconciliation Act of 1986.[1] On average, about 20 percent of the agencies were operating without a waiver at any one time during this period. The chief of HCFA's Operational Initiatives Branch, who conducted the study, advised us that some agencies did not have a waiver due to low utilization (those processing fewer than 10 claims in a 6-month period) and some lost their waiver because they exceeded the 2.5-percent denial criterion. Low utilization providers are not eligible for a waiver of liability. This official also said that HCFA does not have actual or estimated figures on the number of low utilization providers.

Questionnaire Results on Waiver Status

Waiver data for fiscal years 1986, 1987, and 1988 were provided by 8 of the 10 intermediaries in response to our questionnaire.[2] As shown in table 4.1, the percentage of agencies that lost their medical waiver was highest for the period beginning November 1, 1986, when 31.8 percent were without a medical waiver. The percentage of providers without a

[1] As of June 1989, the report being prepared by HCFA was in draft form.

[2] Florida Aetna and South Carolina Blue Cross could not provide all of the requested data for the entire period.

medical waiver remained relatively high for the next 6 months but gradually decreased to about 13 percent by August 1988 (about 21 months later), the lowest rate experienced during the 3-year period. The percentage of agencies without a technical waiver (see p. 14 for discussion of medical and technical waiver) peaked at 4.2 percent for the period beginning November 1, 1988.

Table 4.1: Number of Home Health Agencies Off Waiver (Fiscal Years 1986-88)[a]

Effective date of waiver status[b]	Home health agencies				
	Total serviced	Without medical waiver		Without technical waiver	
		No.	Percent	No.	Percent
02-01-86	1,478	241	16.3	[c]	•
05-01-86	1,494	315	21.1	[c]	•
08-01-86	1,636	404	24.7	[c]	•
11-01-86	1,941	617	31.8	[c]	•
02-01-87	2,381	733	30.8	[c]	•
05-01-87	2,793	746	26.7	[c]	•
08-01-87	3,499	797	22.8	[c]	•
11-01-87	3,566	762	21.4	124	4.0[d]
02-01-88	3,583	628	17.5	102	2.9
05-01-88	3,591	572	15.9	116	3.2
08-01-88	3,148[d]	405	12.9[d]	85	2.7[d]
11-01-88	3,627	548	15.1	152	4.2

[a]Includes data from 8 of the 10 regional fiscal intermediaries; Florida Aetna and Blue Cross and Blue Shield of South Carolina are excluded.

[b]Based on denials from the prior calendar quarter.

[c]Technical waiver became effective July 1, 1987.

[d]Excludes Blue Cross of California, which serves about 400 home health agencies.

Like HCFA's data, our data include providers without a waiver because of low utilization status. When intermediaries identified low utilization providers on their medical waiver reports, they represented as many as 8.5 percent of the total home health agencies served by the intermediaries. Low utilization providers can represent a significant percentage of the home health agencies without waiver for an individual intermediary. For example, for the fourth quarter of fiscal year 1988, Health Care Service Corporation (Illinois Blue Cross) reported that 80 of its 468 agencies were without a medical waiver—40 for low utilization and 40 because the number of denials exceeded 2.5 percent of total visits billed.

Intermediaries' application of HCFA's policy regarding low utilization providers is inconsistent. Depending on which intermediary processes its claims, a home health agency can lose its waiver of liability if it (1) processes fewer than 10 claims in a 6-month period, (2) exceeds the 2.5-percent denial rate regardless of the number of claims processed, or (3) processes fewer than 10 claims in a 6-month period and has more than 2.5 percent of its claims denied in three consecutive quarters.

Problems With Waiver Calculation

For a time, intermediaries were using different methods to calculate denial rates for determining eligibility for a waiver of liability, resulting in different treatment of home health agencies. Some intermediaries were using all visits medically reviewed (which averaged about 62 percent of visits processed) as the denominator in the waiver calculation, while others were using all visits processed. In an October 1986 regional home health intermediary meeting, intermediaries realized that they were calculating the waiver using different methods, brought this to HCFA's attention, and requested clarification. In November 1987, HCFA instructed all intermediaries to use all visits billed as the denominator in calculating denial rates.

Effect of Increased Denials on the Appeals Process

The number of claims appealed to intermediaries and administrative law judges increased substantially as initial denials increased. The percentage of denied claims reversed also increased. This latter increase does not necessarily mean that the claim should have been allowed originally. Many reversals occurred because home health agencies that had not submitted sufficient information with their original claim submitted additional information when they appealed.

The increased appeal activity resulted in increased administrative costs for providers and intermediaries, but quantifiable cost data from the Health Care Financing Administration, intermediaries, or the industry are very limited. The cost to a home health agency for submitting a reconsideration varies depending on the amount of new information submitted. Appeals before a Social Security Administration ALJ are more costly. It costs the Social Security Administration an average of $715 for each appeal. Only about 3,300 ALJ hearings were completed in fiscal year 1988, however.

Appeals Activity Increased Substantially

Table 5.1 shows that the number of reconsiderations and ALJ decisions increased substantially from fiscal year 1986 through 1988. Reconsiderations and ALJ hearings do not necessarily correspond to the denials in the fiscal year due to (1) the 60-day period allowed for filing an appeal and (2) the time required to process the appeal. Nonetheless, it appears from the data that only about 11 percent of the claims denied in fiscal years 1986, 1987, and 1988 were appealed.

Table 5.1: Reconsiderations and ALJ Hearings (Fiscal Years 1986-88)

	FY 1986	FY 1987	FY 1988	Total
Claims processed	5,386,500	5,154,800	5,055,100	15,596,400
Claims denied	321,333	407,826	257,884	987,043
Reconsiderations:				
Completed[a]	9,596	37,853	60,756	108,205
Reversed[b]	2,351	12,023	20,037	34,411
Percent reversed	24.5	31.8	33.0	31.8
ALJ hearings:				
Completed[a]	537	1,179	3,296	5,012
Reversed[b]	349	543	2,447	3,339
Percent reversed	65.0	46.1	74.2	66.6
Total reversed:	**2,700**	**12,566**	**22,484**	**37,750**
As a percent of completed reconsiderations	28.1	33.2	37.0	34.9
As a percent of all denials	0.8	3.1	8.7	3.8

[a]Includes withdrawn and dismissed cases.

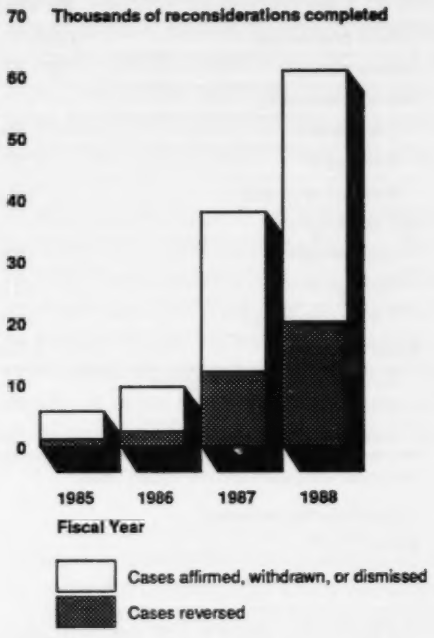
[b]Includes partial reversals.

Source: HCFA

Reversals Have Also Increased

As table 5.1 shows, the percentage of denied claims reversed upon appeal has risen steadily, from about 0.8 percent in fiscal year 1986 to about 8.7 percent in fiscal year 1988.

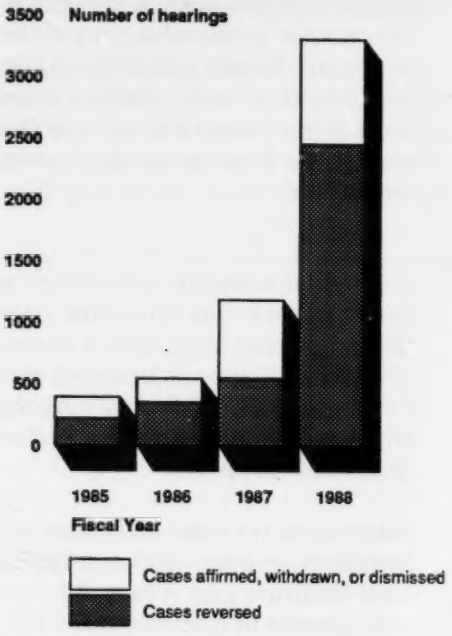
Figure 5.1: Reconsiderations Completed
(Fiscal Years 1985-88)



Source: HCFA.

Also the percentage of completed reconsiderations that resulted in payment of a claim initially denied increased each fiscal year from 24.5 percent in 1986 to 33.0 percent in 1988. The percentage of completed ALJ hearings reversed increased from 65 percent to 74.2 percent, except for fiscal year 1987, when 46.1 percent were reversed. Figures 5.1 and 5.2 show the increase in appeal activity and reversal levels at the reconsideration and ALJ hearing levels during recent years.

Figure 5.2: ALJ Hearings Completed
(Fiscal Years 1985-88)



Source: HCFA.

Reasons for Reversals

Providers contend that many denied claims are reversed on reconsideration without the submission of additional information indicating that the claim was inappropriately denied. Intermediaries and HCFA officials have stated that reversals typically occur at the reconsideration level because additional information is provided[1] and that the initial decision to deny the claim may have been appropriate, given the available data. We visited two home health agencies in Maine and two in Vermont that claimed that reversals were being made by their regional intermediary without the benefit of any new information. When we visited the intermediary, however, we found that all of the reversals cited by the agencies were based on the submission of additional or explanatory information, which allowed the intermediary to reverse the original decision.

[1]Section 3783 of the Medicare Intermediary Manual indicates that the reconsideration of the amount of payment under part A is based on (1) information in the intermediary's possession at the time the initial determination was made, (2) any statements or information that may be submitted by the party or parties, and (3) the medical and other records that are found to be required during the course of the reconsideration. In cases where the evidence taken as a whole is not clear and convincing, a statement from the treating physician is to be obtained, in which the points at issue are discussed.

Several factors contribute to the number of reversals at the ALJ level, according to the HCFA administrator. First, the judge often has additional information gathered as part of the appeals process. Second, the ALJ is technically bound to follow only the law and regulations and is not bound by HCFA instructions or manuals that are not part of the regulations. Therefore, the judge may find in favor of a beneficiary if the reason for the denial is not clearly supported by criteria stated in the law or regulations.

Appeals Cost

We could not identify any central source of data to show what home health appeals cost providers, intermediaries, or government agencies that adjudicate home health appeals. However, we developed estimates of the cost of appeals based on HCFA data on Administrative Budget and Cost reports, Social Security Administration data on Medicare part A and Adversarial Hearings, and discussions with intermediary officials on the cost to appeal.

Administrative costs associated with reconsiderations and ALJ hearings increased between 1985 and 1987 but represent only a small portion of total Medicare part A home health expenditures. The cost for all Medicare appeals to intermediaries, not just home health cases, rose from $3.2 million in fiscal year 1985 to $8.7 million in fiscal year 1987.

In fiscal year 1987 the average administrative costs for an intermediary were about $95 for each reconsideration and $46 for each ALJ hearing. The Social Security Administration's average administrative cost for each Medicare appeal was $715. Using these average costs and the completed case figures in table 5.1 yields an estimated administrative cost to intermediaries and government agencies of about $4.5 million for fiscal year 1987, which represents about 0.2 percent of the $2.3 billion total Medicare part A home health expenditures.

Aggregate information on provider appeal costs is not readily available. The provider's cost of an individual appeal varies. At the reconsideration level, if the agency provides no additional information beyond that submitted with the original claim, the appeals cost would consist of the administrative costs required to complete and mail (1) a Request for Reconsideration of Part A Health Insurance Benefits and (2) an Appointment of Representative form if the provider is representing the beneficiary. In addition to the aforementioned costs, if the agency provided additional information beyond that which was submitted with the

original claim, the cost would increase in proportion to the tasks related to collecting, reviewing, and submitting the additional data.

While appealing denied claims to the ALJ level may be much more costly to providers, there are relatively few ALJ hearings completed (1,179 in fiscal year 1987 and 3,296 in fiscal year 1988). By law, the provider cannot charge the beneficiary any fee for representation before an ALJ and may not be reimbursed if the appeal is unsuccessful.

Recent Changes Affecting the Home Health Program

Administrative actions by the Health Care Financing Administration resulted in declines in denial rates, regional variation in denial rates, and the number of home health agencies that have lost their waiver of liability since early 1987.

Denials Have Decreased

HCFA acted to address some of the reasons cited for the high denial rates of 1986 and 1987, resulting in decreased denials. Specifically:

1. In May 1987, HCFA instructed the intermediaries to stop denying claims solely for missing information and, instead, to request additional documentation needed to process the claim.

2. HCFA's Bureau of Program Operations eliminated two questions from the HCFA form 486 that industry officials felt were leading to increased denials: (1) block 11, which asked, "Is the patient receiving additional medically reasonable and necessary skilled care pursuant to a physician's plan of treatment paid for by other than Medicare?" and (2) block 18, which asked, "Is there an available, able, and willing care giver?" According to industry officials, intermediaries were denying claims based on positive responses to these questions on the grounds that the beneficiary's care needs exceeded the limits of the Medicare benefit or that Medicare-financed services were not needed because of the availability of alternative sources of care. In our opinion, eliminating block 11 from the form would likely decrease denials because this action limits the ability of intermediaries to identify beneficiaries whose care needs exceed Medicare coverage criteria. HCFA's policy provides for denying aide services when there is a family member or other caring person who will provide care. Eliminating block 18 limits the intermediaries' ability to enforce this policy by reducing the amount of information obtained on alternative care givers.

3. HCFA revised the standardized forms and developed a training video to facilitate implementation of the revisions.

The director of HCFA's Bureau of Program Operations said that the extensive training given to home health agencies by the regional fiscal intermediaries on coverage issues and proper documentation of claims also contributed to the reduction in denials.

As a result of these actions, denials decreased considerably (from 9 percent in the first quarter of fiscal year 1987 to 4.3 percent in the third quarter of fiscal year 1989) even though intermediaries continued to

perform medical reviews on about 62 percent of claims processed. As the number of denials has decreased, so has the number of home health agencies that have lost their waiver of liability. While we also expect the number of appealed claims to eventually decrease, the data did not yet reflect a decrease in appeals at the time of our review.

Regional Variation Is Narrowing

As national and regional claims denial rates have generally decreased, regional variation has narrowed. HCFA has taken action to reduce variation in medical review practices by clarifying that claims are not to be denied solely for missing information, and by meeting routinely with the regional intermediaries to discuss medical review, regional nursing practices, and other issues. In addition, home health agencies have had the time to adjust to the medical review practices of their new fiscal intermediaries.

List of Congressional Requesters

House of Representatives

Olympia J. Snowe
Claudine Schneider
David O'B. Martin
Christopher H. Smith
Don Sundquist
Robert Garcia
William F. Goodling
James R. Olin
Gus Yatron
Richard H. Stallings
Peter H. Kostmayer
Arlan Stangeland
Frederick C. Boucher
James H. Saxton
Edward J. Markey
Lynn Martin
James H. Bilbray
Cardiss Collins
Joe Kolter
Lawrence J. Smith
Steve Gunderson
Matthew J. Rinaldo
Butler Derrick
W. J. (Billy) Tauzin
Marge Roukema
Doug Walgren
Paul E. Kanjorski
Gerry E. Studds
Stephen J. Solarz
Robert W. Davis
Harris W. Fawell
Patricia Schroeder
Robert C. Smith
Norman Sisisky
Robert A. Borski
Sherwood L. Boehlert
Virginia Smith
Dale E. Kildee
Wayne Owens
Robert T. Matsui
Dennis E. Eckart
Martin Frost
Byron L. Dorgan

	Bill Green
	William J. Hughes
	Clarence E. Miller
	John J. LaFalce
	Herbert H. Bateman
	Constance A. Morella
	Edward F. Feighan
	Jim Kolbe
	Daniel K. Akaka
	Amo Houghton
	Mickey Edwards
	Mike Synar
	Edward R. Roybal
	Norman D. Shumway
	Ben Nighthorse Campbell
	Larry E. Craig
	Louis Stokes
	Robert Lindsay Thomas
	Ted Weiss
	George W. Crockett, Jr.
	Dan Daniel
	Hal Daub
	Ferdinand J. St Germain
United States Senate	James M. Jeffords

Industry Concerns and Congressional Actions Related to Medicare's Home Health Benefit

The side captions for this appendix represent some of the industry concerns relating to the denial of home health claims. The text that follows describes congressional actions taken in response to each concern.

Too Many Home Health Care Claims Are Being Denied

The Omnibus Budget Reconciliation Act of 1986

- required that the Secretary of Health and Human Services report to the Congress annually in March 1987 and March 1988 on denial activity. The reports were required to address (1) the frequency of denials, (2) the reasons for denials, (3) the extent to which payments were made to providers under the limitation of liability provision, (4) the rate of reversals, and (5) an assessment of the appropriateness of any percentage standard for granting favorable presumption of liability to providers.
- required a demonstration program under which intermediaries will review and decide home health claims shortly after the onset of services.

The Medicare Catastrophic Coverage Act of 1988

- required the Administrator of HCFA to appoint an 11-member Advisory Committee on Medicare Home Health Claims to study the reasons for the increase in denial rates during 1986 and 1987, its ramifications, and the need for reforms. (This provision was repealed by the Medicare Catastrophic Coverage Repeal Act of 1989.)

Denial Letters Do Not Explain Why Claims Are Denied

The Omnibus Budget Reconciliation Act of 1987

- required that intermediaries furnish home health agencies a written explanation citing the statutory and regulatory basis for denying a claim.

Definitions Are Too Stringent and Interpretations Differ Among Intermediaries

The Omnibus Budget Reconciliation Act of 1986

- extended the waiver of liability to technical denials—those based on "not homebound" or "not intermittent care."

The Omnibus Budget Reconciliation Act of 1987

- defined "homebound" and clarified that a beneficiary does not have to be confined to the bed to be considered homebound.
- mandated that rules, requirements, or other statements of policy that establish program changes must be published in the Federal Register and that, not less frequently than every 3 months, a list of all manual instructions, interpretive rules, and statements of policy and other materials be published in the Federal Register.

The Medicare Catastrophic Coverage Act of 1988

- clarified the definition of intermittent services as services either needed for a period of up to 38 consecutive days or needed less than 7 days each week. (Repealed by the 1989 act.)

Administrative Formula for Determining "Favorable Presumption" Is Due to Expire

The Consolidated Omnibus Budget Reconciliation Act of 1985

- extended favorable presumption until 1 year after regional consolidation.

The Omnibus Budget Reconciliation Act of 1986

- required that the Secretary of Health and Human Services prepare a special report on denial activity including an assessment of the appropriateness of any percentage standard established for granting a provider favorable presumption.

The Medicare Catastrophic Coverage Act of 1988

- extended favorable presumption for medical and technical waiver through October 1990. (These provisions were not repealed by the Medicare Catastrophic Coverage Repeal Act of 1989.)

Providers Prohibited From Representing Beneficiaries in Appeals

The Omnibus Budget Reconciliation Act of 1986

- permitted providers to represent beneficiaries in the appeals process.

Appealing Denied Claims Takes Too Long and Costs Too Much

The Omnibus Budget Reconciliation Act of 1986

- required a special denial report including the number of denials reversed on appeal.

The Omnibus Budget Reconciliation Act of 1987

- required the timely processing of reconsiderations.

Many Claims Denied Because of $5 to $1 Savings-to-Cost Ratio Standard

As a result of individual members' inquiries to HCFA,

- HCFA reduced standard to $2 to $1 in March 1987, and eliminated the standard from the fiscal year 1988 Contractor Performance and Evaluation Program.

HCFA's Standardized Forms Create Unnecessary Administrative Burden

The Medicare Catastrophic Coverage Act of 1988

- required the Administrator of HCFA to appoint an 11-member Advisory Committee on Medicare Home Health Claims. (Repealed by the 1989 act.)

Home Health Benefit Is Being Eroded, and Unmet Needs Are Increasing

The Medicare Catastrophic Coverage Act of 1988

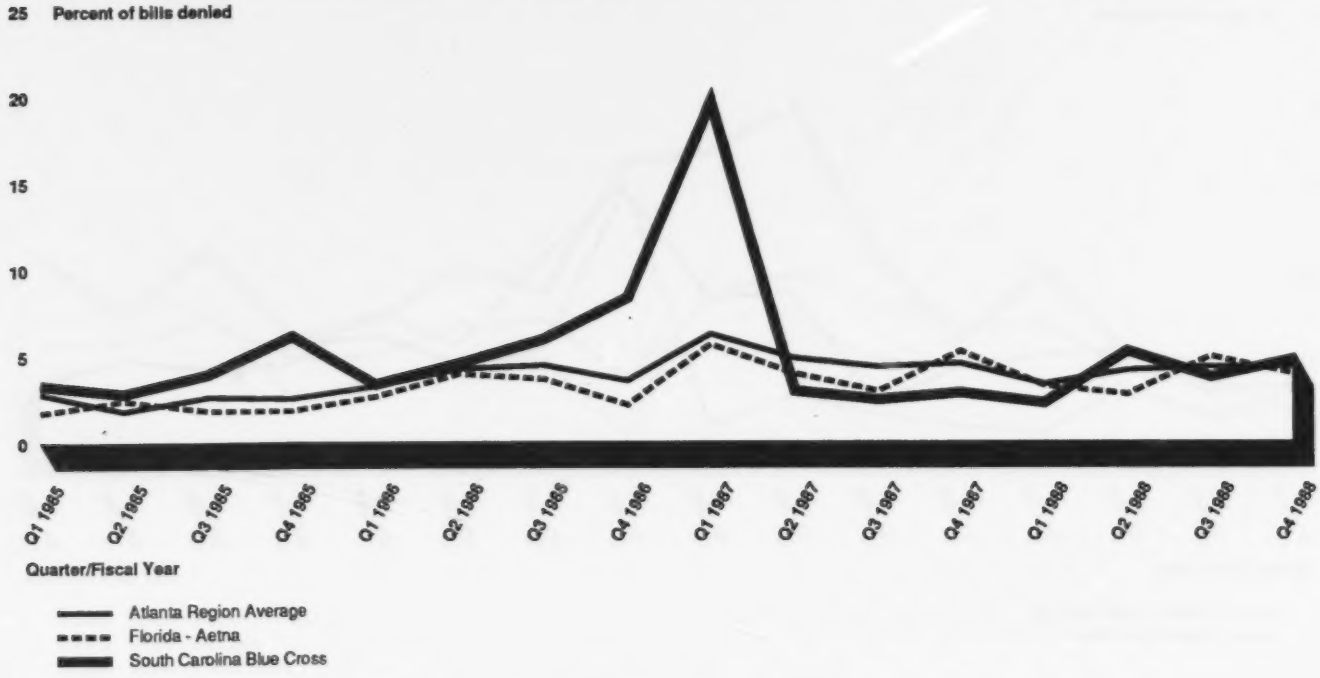
- expanded the number of covered days of daily home care. (Repealed by the 1989 act.)
- expanded benefit to include respite care. (Repealed by the 1989 act.)
- expanded benefit to include intravenous drug therapy. (Repealed by the 1989 act.)

The Older Americans Act Amendments of 1987

- added a new program for support of nonmedical in-home services for the frail elderly.
- authorized consumer protection demonstration project for services provided in the home.

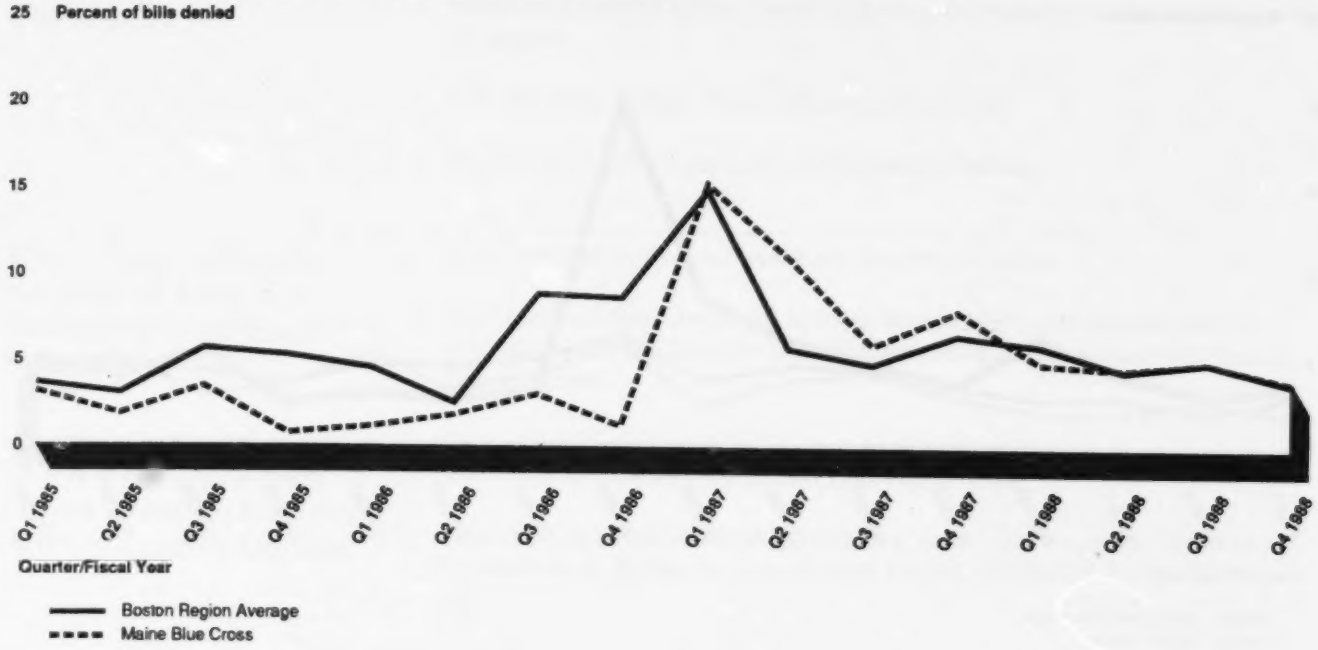
Bill Denials by Region

Figure III.1: Denials of Home Health Agency Bills—Atlanta Region



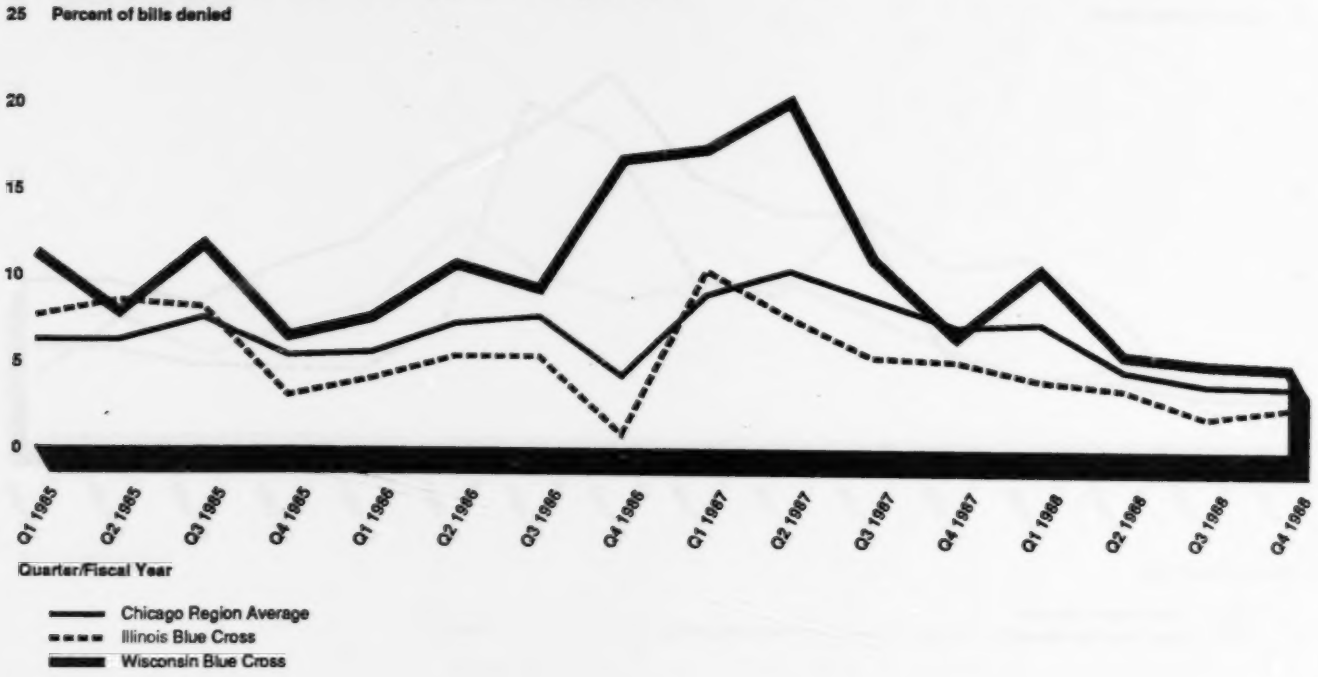
Source: HCFA.

Figure III.2: Denials of Home Health Agency Bills—Boston Region



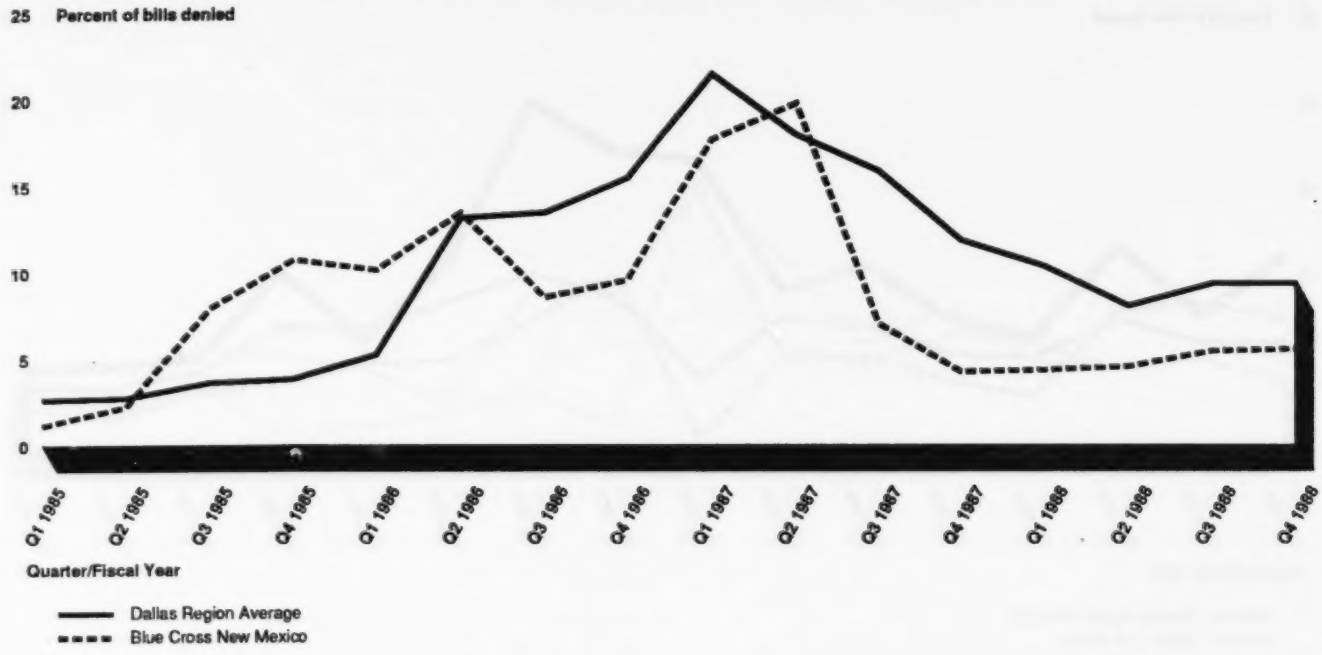
Source: HCFA.

Figure III.3: Denials of Home Health Agency Bills—Chicago Region



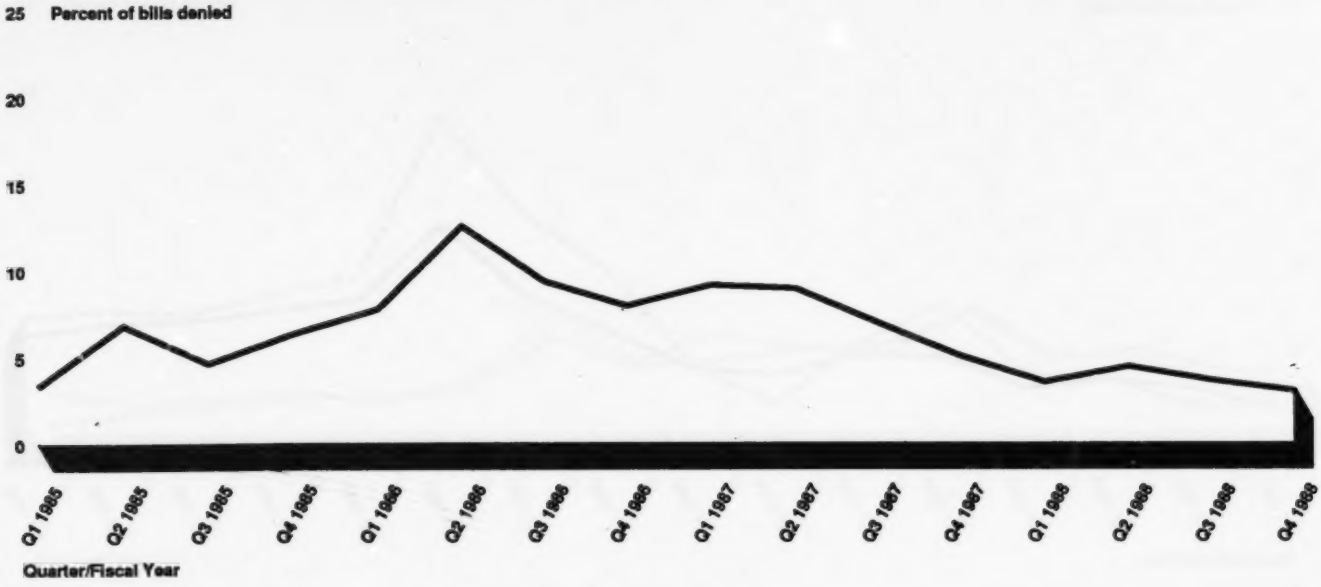
Source: HCFA.

Figure: III.4: Denials of Home Health Agency Bills—Dallas Region



Source: HCFA.

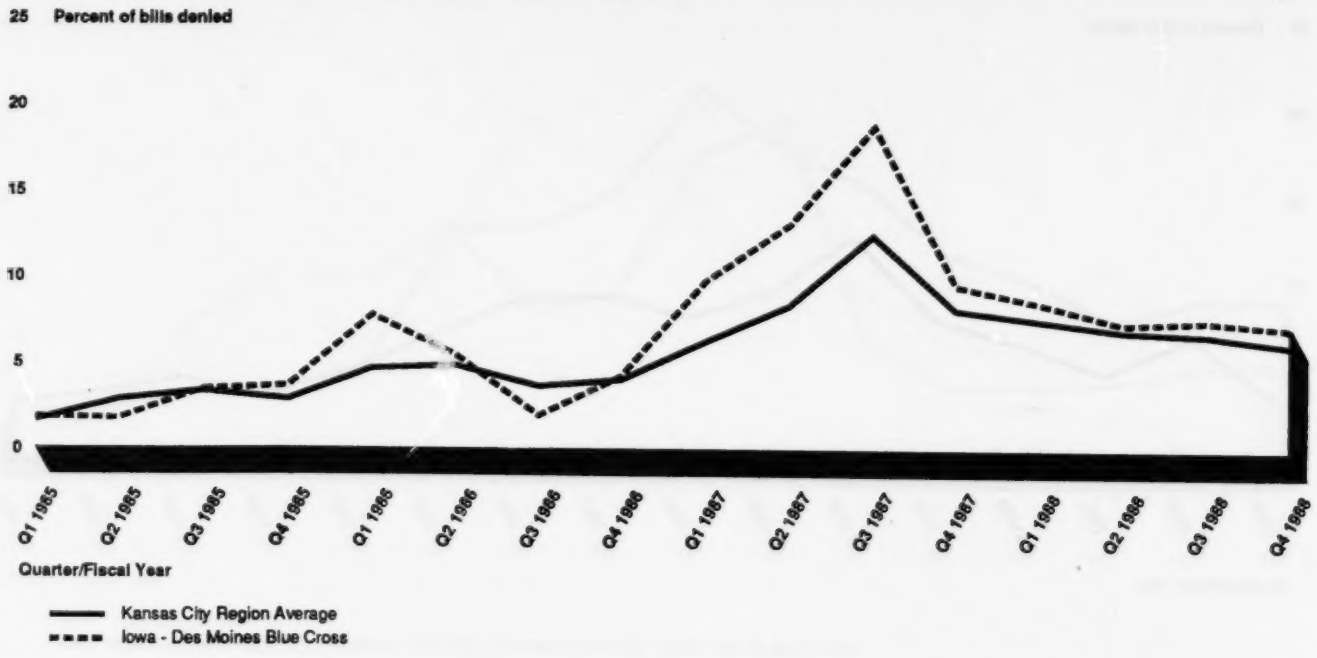
Figure: III.5: Denials of Home Health Agency Bills—Denver Region



Note: Data do not reflect claims processed by Denver's regional intermediary: Blue Cross of Iowa.

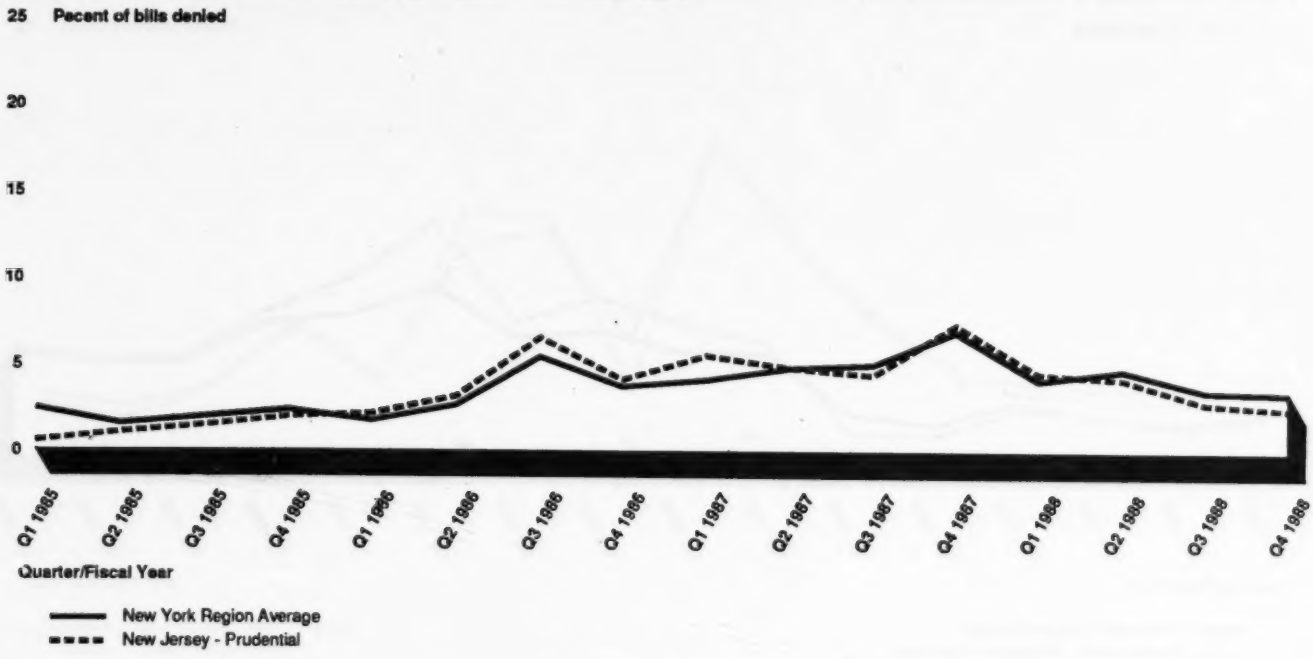
Source: HCFA.

Figure: III.6: Denials of Home Health Agency Bills—Kansas City Region



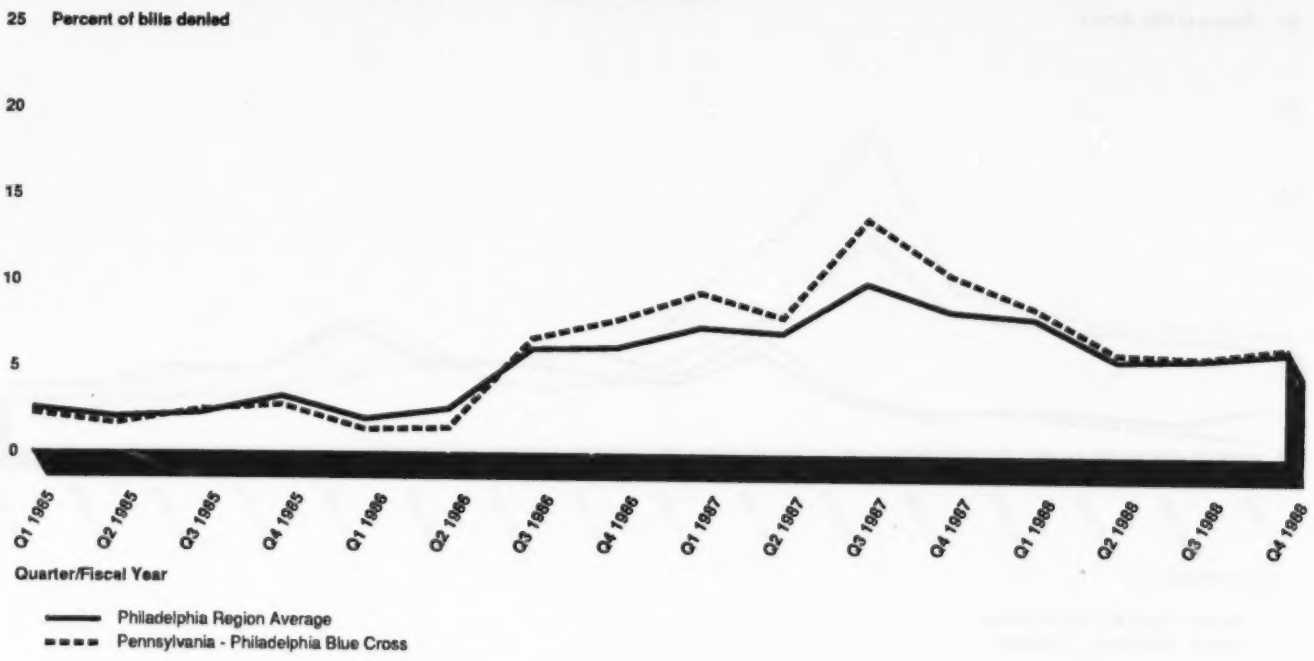
Source: HCFA.

Figure: III.7: Denials of Home Health Agency Bills—New York Region



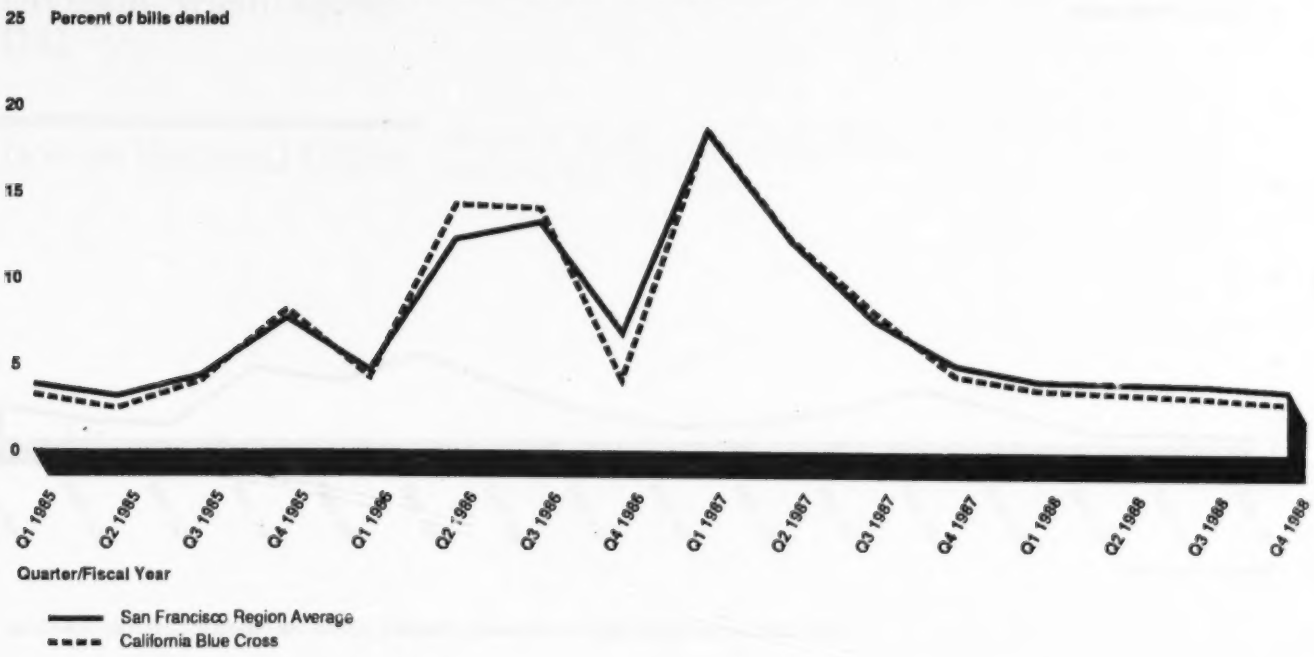
Source: HCFA.

Figure: III.8: Denials of Home Health Agency Bills—Philadelphia Region



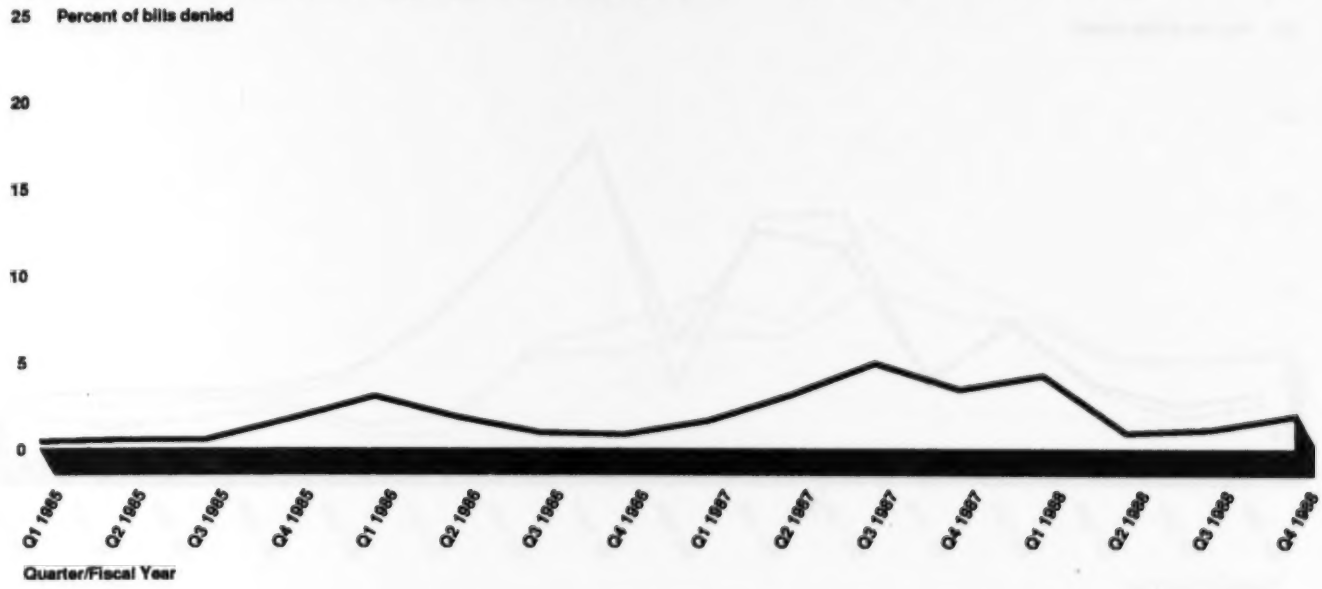
Source: HCFA.

Figure: III.9: Denials of Home Health Agency Bills—San Francisco Region



Source: HCFA.

Figure: III.10: Denials of Home Health Agency Bills—Seattle Region



Note: Data do not reflect claims processed by Seattle's regional intermediary: California Blue Cross.

Source: HCFA.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Jane Ross, Senior Assistant Director, (202) 275-6195 James R. Linz, Assistant Director
Boston Regional Office	William A. Moffitt, Evaluator-in-Charge Teresa D. Dee, Site Senior

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